WC-14 NOTICE OF CLAIM

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

Check one only: ❑ REQUEST FOR HEARING ❑ REQUEST FOR MEDIATION ❑ NOTICE OF CLAIM ONLY

Complete a new Form WC-14 to add an additional employer, insurer or to add date of injury.
If you need additional space, do not alter this form, but instead attach additional sheets. Must be typed or printed in black ink.

Board Claim No.	Employee Last Name	Employee First Name	M.I.	Social Security Number	Date of Injury

A. CLAIM INFORMATION

EMPLOYEE	Birthdate	County of Injury	Address		
Employee E-mail			City	State	Zip Code
EMPLOYER	Name		**INSURER/ SELF- INSURER**	Name	SBWC# (five digit #)
Address			**CLAIMS OFFICE**	Name	
			Claims Address		
City	State	Zip Code	City	State	Zip Code
Employer E-mail			Claims E-mail		
ATTORNEY FOR EMPLOYEE/CLAIMANT	Name		**ATTORNEY FOR EMPLOYER/INSURER**	Name	
Address	GA Bar Number		Address	GA Bar Number	
City	State	Zip Code	City	State	Zip Code
Attorney E-mail			Attorney E-mail		

1. Part of Body Injured	2. First Date Disabled	3. If Fatal – Enter complete date of death Claimants for death benefits (list names & addresses) attach additional sheets

B. HEARING / MEDIATION ISSUES

❑ Income Benefits ❑ TTD(Dates)_____ ❑ TPD(Dates)_____ ❑ PPD(Dates)

❑ Medical Benefits List Benefits

❑ Suspension / Termination Request Effective Date

Reason

❑ Late-Payment Penalties / Assessed Attorney Fees
❑ §34-9-221e ❑ §34-9-108b (1) ❑ §34-9-108b(2) ❑ Other

❑ Catastrophic Designation Specify

❑ Appeal of Rehabilitation Decision Specify

❑ Other Specify

❑ Additional Board Claim Numbers which will be involved (if any): _____
(Complete a separate form WC14 for each date of accident)

C. ENTRY OF APPEARANCE

❑ I hereby certify to the existence of a valid fee contract in compliance with Board Rule 108 or a Form WC-102B in compliance with Board Rule 102. (fee contract or WC-102B has been previously filed or is attached)

D. CERTIFICATE OF SERVICE

❑ I hereby certify that I have today sent a copy of this form to all of the parties named above, and have sent this form to the State Board of Workers' Compensation, 270 Peachtree St., NW, Atlanta, Georgia 30303-1299.

Print Name	Signature	Date

Phone Number	E-mail

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT http://www.sbwc.georgia.gov

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO $10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).

For injuries occurring on or after July 1, 2007, any claim filed with the Board for which neither medical nor income benefits have been paid shall stand dismissed with prejudice by operation of law if no hearing has been held within five years of the alleged date of injury. (O.C.G.A. §34-9-100)